GROUP PROVIDER ENROLLMENT FORM
INSTRUCTIONS

GROUP NAME (field 1) – Enter the group provider name exactly as it is entered on the attached W-9 form. **This is the name you will use to bill the program.**

BUSINESS NAME (field 2) – Enter the name you will be doing business as, if different from above.

BUSINESS TYPE (field 3) – Enter your type of business.

OWNER/ADMINISTRATOR, MANAGING EMPLOYEE or OFFICER OF CORPORATION NAME – (field 4) – Enter the name of the owner/administrator, manager or chief operating officer of your business or facility.

FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)– (field 5) –Enter the group FEIN (9 - digits).

SERVICE LOCATION ADDRESS – (field 6) – Enter the complete physical address of the location of the business or where the actual services are conducted. **P.O. Box alone is not acceptable as a service location.**

PAY TO ADDRESS – (field 7) – Enter the complete address of the location where financial correspondences should be forwarded. Examples: Remittance Advice/RA, Explanation of Benefits/ EOB.

MAIL TO ADDRESS – (field 8) – Enter the complete address of the location where correspondences should be forwarded. Examples: Direct Mailings regarding billing, policy related changes, etc.

TELEPHONE/FAX – (field 8) – Enter the area code and telephone and fax number of the location where direct mailings are mailed.

BILLING SERVICE ADDRESS – (field 9) – Enter the complete address of the location where the billing information is prepared.

BILLING TELEPHONE/FAX – (field 9) – Enter the area code and telephone and fax number of the location where the billing information is prepared for billing inquiries. Also, provide a Mobil number, if applicable.

ADDITIONAL PRACTICE LOCATIONS ADDRESS – (field 10) – Enter the complete physical address of additional location(s) of the business or where the actual services are conducted. If more than 3 locations please provide information on a separate sheet of paper and include with this application.

OFFICE EMAIL ADDRESS – (field 11) – List the office email address for the actual provider (doctor) to receive future correspondences via email.

CONTACT PERSON – (field 11) – Please indicate who the main contact person is for the group.

CURRENT ENROLLMENT WITH MEDICAL ASSISTANCE – (field 12) – If you have been enrolled previously with RI Medical Assistance as an individual or within an established group, please provide your Medical Assistance ID number/s.

MERGER/BUY OUT – (field 13) – Is this enrollment due to a purchase of an established practice?

OUTSTANDING BALANCE – (field 14) – List any outstanding balance owed to RI Medical Assistance from a previous enrollment.

MEDICAL SPECIALTY – (field 15) – Enter the appropriate Specialty; e.g., MD - Internist; DDS - Oral Surgeon. (Disregard if you provided your NPI & Taxonomy/ies).

NATIONAL PROVIDER IDENTIFIER – (field 16) – Enter the CMS (Centers for Medicare/Medicaid) established NPI number for the group. (CMS is stating that providers who are incorporated need to be enrolled as a group with their group (type 2) NPI.) Also include your authorization letter from the Enumerator/contractor NPPES. If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY(ies) – (field 17) – Enter the Taxonomies established by CMS.

EMC BILLER – (field 18) – If you intend to bill via electronic media, please fill out the EMC interest form/Trading Partner Agreement. http://www.dhs.ri.gov/dhs/heacre/provsvcs/prvforms/tpa.pdf.

FISCAL YEAR END – (field 19) – Enter the month in which your fiscal year ends.

ENROLLMENT EFFECTIVE DATE or DATE FIRST SERVED RIMA client – (field 20) – If a Medical Assistance client is currently under your care, please provide the date in which you began services, **or** Provide a date in which you are interested in establishing your practice as a Medical Assistance Provider.

EXCLUSIONS UNDER THE CODE OF FEDERAL REGULATIONS – (field 21) – If YES, provide information relating to any exclusions under Chapter 42, Public Health, Department of Health and Human Services.

DOCUMENT DEBARMENT, SUSPENSION, EXCLUSION, CRIMINAL OFFENCE FROM FEDERAL PROGRAM – (field 22) – Provide any information/documentation pertaining to any debarment, suspension, exclusion, or criminal offence from a federal program.

PROVIDER SIGNATURE AND DATE – Application must be signed by the Authorized Group Agent. **Stamped or photocopied signatures are not acceptable.**

MAIL TO:

EDS / Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 02887-2010

Requests for updates to your provider file, such as name or address changes, must be signed by the provider or authorized administrator and sent to the address above.

An incomplete application will be returned for completion.
Avoid this delay by submitting a complete application.